Commonwealth of Massachusetts
Health Care Quality and Cost Council
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Chair

KATHARINE LONDON
Executive Director

Health Care Quality and Cost Council

Meeting Minutes

Wednesday, February 6, 2008, 1:00 – 3:00 p.m.
One Ashburton Place, Ashburton Café, Boston, MA

Council Members Present: JudyAnn Bigby, Charles Baker, Kevin Beagan, Elizabeth Capstick, James Conway, David Friedman, Kenneth LaBresh, Thomas Lee, Shannon Linde, Katharine London, Robert Seifert, Greg Sullivan, and Catherine Moore representing Dolores Mitchell.

Meeting called to order at 1:05 pm

I. Approval of Minutes of Council Meeting January 16, 2007

The Council approved the minutes of its January 16, 2008 meeting.

II. Executive Director's Report

- Council agenda: Katharine London distributed a draft agenda for Council meetings from February through June. The draft agenda lists potential speakers on issues related to cost containment and quality improvement, as well as a schedule for Council business. Katharine proposed moving to 3 hour monthly meetings beginning in April instead of 2 hour twice-monthly meetings. This schedule may reduce Councilors' travel time, and will allow the Council to have more in-depth discussions. The Council agreed to this schedule change.

- Budget: The Governor included $1.9m for the Council in his FY09 budget, up from the Council's $1.3m FY08 spending (which included $300K carried over from FY07 plus a $1m FY08 appropriation), but less than the $2.3m the Council requested. The Governance Committee reviewed the budget at its February 5, 2008 meeting. The Council will receive price proposals from its Analytic, Operations and Web Application Development vendors over the next few weeks. Council staff will use that cost information to evaluate whether the proposed funding will be sufficient to accomplish the Council's statutory mandate.

- Web Application: Katharine expects to have recommendations for the Council on Feb 20 for 3 vendors: Analytic Consultant, Operations, and Web Application Development. We should have the Analytic Consultant recommendation later today, but want to consider all 3 together, in order to make the best use of our limited funding.

- Personnel: We have selected a candidate for the Executive Assistant position, and are working through the hiring process.

III. Items for Discussion

A. Update on Claims Data Submissions
Suanne Singer, Maine Health Information Center

Suanne Singer reported that 8 health insurance carriers met the data quality requirements to submit the full 5 quarters of medical claims data. 11 health insurance carriers met the data quality requirements to submit pharmacy claims data. The MHIC is in regular communication with all data submitters: weekly conference calls with the larger carriers, and regular emails with the smaller carriers. Suanne expects several other plans to pass the requirements this week, and to have a full dataset ready in 5 weeks.

Suanne expressed a concern that MEGA and Midwest had not submitted any test data since early January. Kevin Beagan offered to raise the issue in the Division of Insurance's biweekly meeting with MEGA/Midwest, and offered his assistance with any carrier not responding in a timely manner.

B. Approval of Policy for Penalizing Health Insurance Carriers for Failing to Submit Required Data (*vote)

The Council reviewed the proposed policy. Council staff developed the policy based on the requirements in MGL c.6A, s.16L, and used the Maine Health Data Organization's fining policy as a model. David Friedman proposed the following amendment.

> In Part A, Response point 2 is hereby amended by adding the following sentence:
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> "Provided, however, that if, within the past 12 months, the Council has ordered that the health insurance carrier pay a penalty for failure to provide required information, the Council Chair may forego written notice under this step and refer the matter directly to the full Council pursuant to step 3."

The Council approved the policy, as amended, 11 votes for, 0 opposed. Charlie Baker abstained from the vote because of a potential conflict of interest.

C. Recommendations to be Included in the Council's Annual Report to the Legislature

The Council discussed the proposed recommendations. Katharine London suggested that they were not quite ready for approval, especially because the End of Life Committee had just suggested a number of changes to that section. Jim Conway said that the End of Life recommendations were directionally consistent, but that the

Committee is still fine-tuning them. The Committee wants to make sure that the recommended measures are not burdensome, that there is clear accountability for each recommendation, and that the Committee's recommendations are consistent with national trends.

Tom Lee expressed a concern about recommending an overall mortality measure in the Patient Safety section. Beth Capstick pointed out that the Patient Safety Committee had originally proposed a more aggressive timeline, but had pushed it back to allow for more review and analysis of the measure.

Greg Sullivan requested that the ad hoc committee be convened to look at the cost goal, and schedule steps moving forward, as cost containment should be the Council's number one priority.

IV. Presentation: Massachusetts Health Care Spending
Sarah Iselin, Commissioner, MA Division of Health Care Finance and Policy

Commissioner Iselin presented background information on health care spending in Massachusetts for the period 1997 through 2004. She noted that health care spending in Massachusetts is the highest in the nation, and that Massachusetts doubled during this time period. Massachusetts health care spending grew only slightly faster than the national average over this time period. Hospital-based expenditures account for half of the difference between Massachusetts and US per capita spending, and Massachusetts per capita spending exceeded the national average in every spending category.

Commissioner Iselin's powerpoint presentation is available on the Council's website at www.mass.gov/healthcare.

V. Presentation: Reducing the Health Care Spending Trend in Massachusetts
Meredith Rosenthal, Associate Professor of Health Economics and Policy Harvard School of Public Health

Professor Rosenthal's presentation included the following points. Her full presentation is available on the Council's website at www.mass.gov/healthcare.

Causes of Spending Growth Are Many

- New technologies are introduced and not rationed based on effectiveness, let alone cost effectiveness
- Physicians, hospitals are paid to do more (sometimes with a lag in the hospital, but revenues track costs fairly well)
- Consumers have little or no incentive to resist the pitch for cutting edge devices, drugs, tests an no information on which ones are worthwhile
- Fragmentation of care causes redundancy, dropped handoffs, poor coordination for chronically ill

Solutions Should Also be Manifold

- We need payment reform to promote high-value services and curb the tendency towards over use of expensive care by providers. Alternatives include:
    - Case rates for primary care with prospective accountability and performance incentives
    - Episode based payment: global longitudinal
    - Shared savings models
- We need sensible cost sharing for patients
- We need payment and benefit designs that together support "medical homes"
- We need the Commonwealth to invest in public health because no one else will

Public Health and Social Change

- Payment and benefit design changes are efforts to row upstream
- Changing the current requires:
    - Investing in public health broadly conceived -- campaigns against tobacco, obesity
    - Convincing people that more high-tech services does not mean better quality
    - Making everyone, including physicians, accept stewardship for the system